Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT SURGERY CENTER
PO BOX 678692
DALLAS TX 75267

Respondent Name

HARTFORD CASUALTY INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-2733-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Codes are not inclusive to other codes."

Amount in Dispute: $26,560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 26445 global to CPT 26520. Please see attached." "CPT 11043 agree to pay per fee schedule. Please see attached."

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2010	ASC Services for CPT Codes 26445-SG-78 (X2) and 11043-SG-78	$26,560.00	$1,554.38

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 14, 2010
   - 97-Payment is incl in the allow for another sevc. The Srvcs listsed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed. [sic]

Explanation of benefits dated November 23, 2010

- 193-Original payment decision is being maintained. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. This bill was previously paid.

Issues

1. Was payment issued for CPT code 11043-SG?
2. Did the requestor support position that code 26445-SG is not global to another procedure performed on the disputed date of service?
3. Did the requestor support position that reimbursement is due for ASC services for code 26445-SG-78? Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position summary that "CPT 11043 agree to pay per fee schedule. Please see attached."

   On February 8, 2012, the Division contacted the requestor's representative, Jan Small, and verified that CPT code 11043 was paid by the respondent. Therefore, the disputed issue for CPT code 11043-SG-78 is resolved and will not be considered further in this decision.

2. According to the explanation of benefits, the respondent denied reimbursement for the ASC services billed under CPT code 26445-SG based upon denial reason code "97".

   On the disputed date of service, the requestor billed the following CPT codes: 64831-SG-78 x2, 14040-SG-78, 26445-SG-78 x2, 26520-SG-78, 26525-SG-78 x2, and 11043-SG-78.

   CPT code 26445 is defined as "Tenolysis, extensor tendon, hand OR finger, each tendon."

   The respondent states in the position summary that "CPT 26445 global to CPT 26520. Please see attached."

   Per National Correct Coding Initiatives, HCPCS code 29520 and 26445 are not global; therefore, the disputed services will be reviewed per 28 Texas Administrative Code §134.402.

3. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPT code 26445 is:
   The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures.
   The ASC fully implemented relative payment weight for CY 2010 = 15.9138.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 15.9138 X $41.873 = $666.35.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $333.17 ($666.35/2).

   This number X City Conversion Factor/CMS Wage Index for Plano, Texas is $333.17 X 0.9853 = $328.27.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $328.27 + $333.17 = $661.44.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $661.44 X 235% = $1,554.38.

   CPT code 26445 is subject to multiple procedure rule discounting; therefore, $1,554.38 X 50% = $777.19.

   The requestor billed for two units of CPT code 26445.

   The operative report indicates that the claimant underwent "tenolysis, release of extensor tendon mechanism x 2, extensor propria, extensor dlglti quinti; therefore, the requestor supports billing of two units.

The MAR for CPT code 26445 is $777.19. This amount multiplied by 2 units is $1,554.38. The insurance carrier paid $0.00. The difference between amount due and paid equals $1,554.38. This amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $1,554.38.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,554.38 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.